THERAPIST/COUNSELOR REPORT

Due:

Profession:
Case #:

DOPL
ATTN: PROBATION / URAP
PO BOX 146741
SALT LAKE CITY UT 84114-6741

Dates Seen:_____
Length of Sessions:_____

Were there any missed appointments?
NO____ YES____ How many?_____

Name of Licensee:
Questions? Call 530-6428 or 530-6718
FAX: (801) 530-6511

Have you read the conditions of licensee's Contract/Order? YES____ NO____

Diagnosis (DSM-4 Axis I-V) _____
_____

Please list current medications:_____
_____

What are the major issues being addressed in therapy?_____
_____

Please list the goals of treatment:_____
_____

Please comment in detail on how the licensee is doing with regard to relevant issues. Include at least the following: recognition and insight into problems, interaction during sessions, ability to solve problems and compliance with recommendations. _____
_____
_____
_____

Evaluation of Progress_____
_____
_____

Is Licensee in Compliance with Treatment Plan? YES ____ NO_____

In your opinion, is Licensee safe to Practice? YES_____ NO_____

_____
Name (Please Print)

_____
Signature of Therapist

_____
Title (Please Print)

_____
Date

(Fold and mail in window envelope when completed)